

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03532					CERTIFICATE OF DEATH					05078	
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 40 minutes d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital Inc.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsburg d. STREET ADDRESS 09-1					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles MacAuthor Aldridge			First Middle Last			4. DATE OF DEATH March 14 19 67		Month Day Year			
5. SEX male		6. COLOR OR RACE negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/14/67		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min. 40	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles MacAuthor Aldridge						14. MOTHER'S MAIDEN NAME Diane Sheffield					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT mother Williamsburg, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis 7625 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) Prematurity DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 3/14 , 1967, to 3/14 , 19 67 , that (I) (we) last saw the deceased alive on 3/14 , 19 67 , and that death occurred at 1:10M , from the causes and on the date stated above.											
22a. SIGNATURE [Signature]				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 3-14-67			
22c. PHYSICIAN'S NAME (Type) Dr. J. Edwin Fassett				22d. ADDRESS 623 High Street, Cambridge, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/18/67		23c. NAME OF CEMETERY OR CREMATORY Bethel		23d. LOCATION (City, town or county) (State) Cambridge, Md.					
24. FUNERAL DIRECTOR St Clair-521 High St. Cambridge, Md						25a. REC'D BY REGISTRAR APR 27 1967		25b. REGISTRAR'S SIGNATURE [Signature]			

05050

1990

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
03533						CERTIFICATE OF DEATH						03528	
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 40 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 1405 Race Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) BERTIE MAY BOOZE First Middle Last						4. DATE OF DEATH March 27 1967 Month Day Year							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 21, 1900		9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Hudson, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John R. Hubbard						14. MOTHER'S MAIDEN NAME Daisy May Marshall							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. unk		17. INFORMANT Address Mr. Milton L. Booze, Cambridge, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DISEASE WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Pancreatitis 584X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Common Duct Stone DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 4 days unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 3-23, 1967 to 3-27, 1967 that (I) (we) last saw the deceased alive on 3-27 1967 , and that death occurred at 4:25 PM , from the causes and on the date stated above.													
22a. SIGNATURE W. Baumann						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) Wilbur N. Baumann, M.D.						22d. ADDRESS 10 Aurora St., Cambridge, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 29 1967		23c. NAME OF CEMETERY OR CREMATORY Spedden-Seward Cemetery				23d. LOCATION (City, town or county) (State) James, Dor. Co., Maryland					
24. FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service, Cambridge, Maryland						25a. REC'D BY REGISTRAR DATE MAR 31 1967		25b. REGISTRAR'S SIGNATURE [Signature]					

03528

03528

Humanistic Psychology
Course List

Humanistic Psychology

3-27 07

3-27 07

William

In person, United States

United States, United States, United States

United States, United States, United States

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03534					03529						
PLACE OF DEATH a. CDUNITY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
Dorchester					Maryland						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b						
Cambridge					25 Years						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM?						
313 Talbot Ave.,					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
Ida			Ann		Bradley		March 6, 1967		19		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Dec. 2, 1880		66 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Homemaker								Cambridge, Md., R.D.		U.S.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
William Shannahan						Margaret Phillips					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT					
No						313 Talbot Ave., Mrs. Wm. F. Brohawn, Cambridge, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage 331X DUE TO Cerebral arterio-sclerosis (b) DUE TO Arterio sclerosis generalized (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage with left Hemiplegia 2-6-67										INTERVAL BETWEEN ONSET AND DEATH 5 - 10 Min. 1 - 2 yrs. 5 - 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from 2-6-1967, to 3-6-67, 1967, that (I) (we) last saw the deceased alive on 3-4-1967, and that death occurred at 4:15 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Eldridge H. Wolff						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-6-67			
22c. PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M. D.						22d. ADDRESS 6 Aurora Street, Cambridge, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF March 8, 1967		23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery		23d. LOCATION (City, town or county) (State) Cambridge, Md.			
24. FUNERAL DIRECTOR Kenneth P. Thomas						ADDRESS Cambridge, Md.		25a. RECD BY REGISTRAR MAR 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

82584

82584

82584

Cerebral hemorrhage with left hemiparesis 3-4-67

Arterio sclerosis generalized

Cerebral arterio-sclerosis

Myocardial degeneration

1-4-67

1-4-67

1-4-67

Wolfe, H. D.

Arthur, H. D.

James, H. D.

James, H. D.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
03535		Item #16 Film #G301 3/23/67 pc		03530							
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>4 months</u>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural, Finksburg</u>				d. STREET ADDRESS <u>16-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>407 Oakley St.</u>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Ruby</u> Middle <u>Pratt</u> Last <u>Brubaker</u>			4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1967</u>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>17 April 1881</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Breckenridge Missouri</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Henry Charles Pratt</u>						14. MOTHER'S MAIDEN NAME <u>Harriett Morse</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-52-5899</u>		17. INFORMANT <u>Mrs. Alton Sellers</u>		Address <u>Cambridge Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4301</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u></u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3/10/67</u> Address (Street, city, town, or county) <u>Cambridge, Md.</u>											
ACTUAL SIGNATURE <u>John Mace Jr.</u>		EXAMINER'S NAME (Type) <u>John Mace Jr. M.D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>13 Mar 1967</u>		22c. NAME OF CEMETERY OR CREMATORY <u>All Saints Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>Reisterstown Md.</u>					
23. FUNERAL DIRECTOR <u>Henry H. H. H.</u>		ADDRESS <u>Cambridge Md. 21613</u>		24a. REC'D BY REGISTRAR <u>MAR 14 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

FOR STATE HEALTH DEPT

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03536		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				03531			
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN lb 40 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 900 Race Street					d. STREET ADDRESS 900 Race Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATHERINE Middle KINCAID Last BUSICK					4. DATE OF DEATH Month March Day 15 Year 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 27, 1881		9. AGE (In years last birthday) yrs. 85	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Cuyahoga Falls, Ohio			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unk					14. MOTHER'S MAIDEN NAME Unk				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-20-8495A		17. INFORMANT Mr. James G. Busick, Cambridge, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1201 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) John Mace Jr. M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cambridge, Md.				
22. DATE SIGNED 3/18/67									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 18, 1967		23c. NAME OF CEMETERY OR CREMATORY Old Trinity Cemetery		23d. LOCATION (City or Town) (County) (State) Church Creek, Maryland			
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland					25a. REC'D BY REGISTRAR MAR 21 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

18800

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MAR 2 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03537 Item 9 Film 6389 2/23/67 KK 05085											
1. PLACE OF DEATH a. COUNTY DORCHESTER b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CAMBRIDGE c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY DORCHESTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE, MD d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Hattie Middle Christian Last 4. DATE OF DEATH Month 3 Day 22 Year 1967						5. SEX Female 6. COLOR OR RACE NEGRO 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 7/12/1900 9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (County & State, or foreign country) DORCHESTER						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME IDA MASON					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO. INFORMANT Address Robert Christian					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation DUE TO (b) arteriosclerotic cardiovascular disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 2-1-1967 to 3-22-1967 , that (I) (we) last saw the deceased alive on 3-22-1967 , and that death occurred at P.M. from the causes and on the date stated above.											
22a. SIGNATURE J. Edwin Fassett M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett 22d. ADDRESS 623 High St Cambridge, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY Bethel 23d. LOCATION (City, town or county) (State) Cambridge											
24. FUNERAL DIRECTOR'S SIGNATURE West Penn Home Cambridge, Md. ADDRESS 25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE May 3 1967											

MEDICAL CERTIFICATION

02082

02082

[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]

03538

CERTIFICATE OF DEATH

03532

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston - RURAL</u>	
c. LENGTH OF STAY IN 1b <u>2 yrs.</u>		d. STREET ADDRESS <u>15-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert D. Cox</u>		4. DATE OF DEATH <u>3/13</u> 19 <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-86</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>27</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland-TALCO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Cox</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Biery</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u>214-32-7279</u>	
17. INFORMANT <u>Records - Hospital</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u></u> , 19 <u></u> , to <u></u> , 19 <u></u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>3:13 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Pete W. Rieckert</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u></u>	
22c. PHYSICIAN'S NAME (Type) <u>Pete W. Rieckert</u>		22d. ADDRESS <u>E-New Market Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>	23b. DATE THEREOF <u>3-15-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Preston Pa. Ind</u>
24. FUNERAL DIRECTOR <u>Walter Lamb</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAR 15 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF OHIO

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CERTIFICATE OF DEATH

03539

03533

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 114 Oakley Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROWENA Middle MEREDITH Last CREIGHTON				4. DATE OF DEATH Month March Day 3 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 13, 1920	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months 46 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward L. Meredith				14. MOTHER'S MAIDEN NAME Georgia Sherman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unk		17. INFORMANT Mr. E. Hallie Creighton, Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral metastasis and 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Metastasis to lumbar vertebra & right lung DUE TO (c) Ca. of cervix (Invasive squamous cell carcinoma) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (Ca. adequately ? treated)						INTERVAL BETWEEN ONSET AND DEATH 1 week ? 8 mo. 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from 3-9- , 19 64 , to 3-3- , 19 67 , that (I) was saw the deceased alive on 3-3- , 19 67 , and that death occurred at 11:15 from the causes and on the date stated above.							
22a. SIGNATURE Eldridge H. Wolff				22b. DATE SIGNED 3-5-67		22c. PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M. D.	
22d. ADDRESS 6 Aurora Street, Cambridge, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 6, 1967		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City, town or county) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland				25a. REC'D BY REGISTRAR MAR 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 2 and 3) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

03534

03540

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. LENGTH OF STAY IN lb <u>42 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp.</u>		d. STREET ADDRESS <u>RFD #3 - Box 169</u>	
3. NAME OF DECEASED (Type or print) <u>Percy Lee Demby</u>		4. DATE OF DEATH <u>March 24 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-21-04</u> 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Demby</u>		14. MOTHER'S MAIDEN NAME <u>Rester Tilghman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>22-16-1802</u>	
17. INFORMANT <u>Records - Hospital</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, acute</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Atherosclerotic Heart Disease</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from <u>3/22, 1967</u> , to <u>3/24, 1967</u> that the (we) last saw the deceased alive on <u>3/24 1967</u> , and that death occurred at <u>4:25 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Donald R. Hylleberg</u> M.D.		22b. DATE SIGNED <u>3/24/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW CHAPEL</u>	23d. LOCATION (City or Town) (County) (State) <u>CHAPEL TALBOT MD</u>
24. FUNERAL DIRECTOR <u>Washell Funeral Home</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05250

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

03541

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Vienna - Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital		d. STREET ADDRESS R.F.D. #1, Box 219	
3. NAME OF DECEASED (Type or print) First ELWOOD Middle LUTHER Last DENNIS		4. DATE OF DEATH Month March Day 24 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1918
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Edward Dennis		14. MOTHER'S MAIDEN NAME Martha Collins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-07-3838	
17. INFORMANT Sarah E. Dennis, Vienna, Md., RFD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 982X IMMEDIATE CAUSE (a) Hemorrhage, stab wound of heart. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was stabbed by wife.	
20c. TIME OF INJURY Month, Day, Year 6 PM 3/24/67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Reid's Grove, Dor.. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		22. DATE SIGNED 3/29/67	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 29, 1967	
23c. NAME OF CEMETERY OR CREMATORY Reid's Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Near Rhododale, Md.	
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalburg, Maryland		25a. APPROVED BY REGISTRAR APR 6 1967	
25b. REGISTRAR'S SIGNATURE J. J. Frampton		25c. REGISTRAR'S SIGNATURE J. J. Frampton	

1950

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

03542

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03535

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MD. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE			c. LENGTH OF STAY IN lb 6 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN 14-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES GODFREY DILLON				4. DATE OF DEATH Month Day Year MARCH 13 19 67			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/29/05	
9. AGE (In years lost birthday) yrs. 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HEATING ENGINEER		11. BIRTHPLACE (State or foreign country) CALIFORNIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JAMES RICARDS DILLON				14. MOTHER'S MAIDEN NAME MARY MCINTYRE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 282-03-7278		17. INFORMANT HOSPITAL RECORDS Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 963X IMMEDIATE CAUSE (a) MENINGITIS DUE TO OLD GUN SHOT WOUND BRAIN ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 6 YRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. XXX		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SHOT SELF WITH 22 GUN.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. SPRING 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) CHESTERTOWN KENT MD.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) JOHN MACE JR.				22. DATE SIGNED 3/13/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 3-14-67		23c. NAME OF CEMETERY OR CREMATORY SILVERBROOK CREMATORY		23d. LOCATION (City or Town) (County) (State) WILMINGTON, NEWCASTLE, DEL.	
24. FUNERAL DIRECTOR <i>Victor N. Kennedy</i> ADDRESS STILLBOND, MD.				25a. REC'D BY REGISTRAR DATE MAR 15 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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UNIT 1112

UNIT 1112

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03543

CERTIFICATE OF DEATH

03536

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY WOR.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE		c. LENGTH OF STAY IN lb 13 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY FRANCES DRYDEN		4. DATE OF DEATH Month MARCH Day 21 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/26/79
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (County & State, or foreign country) MD.		13. CITIZEN OF WHAT COUNTRY? U.S.	
14. FATHER'S NAME SID BURKE		15. MOTHER'S MAIDEN NAME MARY HADDOCK	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		17. SOCIAL SECURITY NO. -	
18. INFORMANT HOSPITAL RECORDS		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) DIABETES			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/12 , 19 53 , to 3/21 , 19 67 , that (I) (we) last saw the deceased alive on 3/21 19 67 , and that death occurred at 11:25M , from causes and on the date stated above			
22a. SIGNATURE <i>Efrain C. Hernandez</i>		22b. DATE SIGNED 3/21/67	
22c. PHYSICIAN'S NAME (Type) <i>Efrain C. Hernandez</i>		22d. ADDRESS E.S.S. HOSPITAL, CAMBRIDGE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 24, 1967	23c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Snow Hill Maryland
24. FUNERAL DIRECTOR <i>Thomas F. Williams</i>		25a. REC'D BY REGISTRAR DATE MAR 27 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05252

COMPONENT OF DATA

03243

1. NAME OF THE PERSON OR ORGANIZATION		2. ADDRESS		3. CITY		4. STATE		5. ZIP CODE	
6. TITLE		7. PHONE NUMBER		8. FAX NUMBER		9. E-MAIL ADDRESS		10. OTHER CONTACT INFORMATION	
11. DATE OF BIRTH		12. DATE OF DEATH		13. DATE OF ENTRY		14. DATE OF EXIT		15. DATE OF REENTRY	
16. DATE OF DEPARTURE		17. DATE OF RETURN		18. DATE OF REENTRY		19. DATE OF EXIT		20. DATE OF REENTRY	
21. DATE OF DEPARTURE		22. DATE OF RETURN		23. DATE OF REENTRY		24. DATE OF EXIT		25. DATE OF REENTRY	
26. DATE OF DEPARTURE		27. DATE OF RETURN		28. DATE OF REENTRY		29. DATE OF EXIT		30. DATE OF REENTRY	
31. DATE OF DEPARTURE		32. DATE OF RETURN		33. DATE OF REENTRY		34. DATE OF EXIT		35. DATE OF REENTRY	
36. DATE OF DEPARTURE		37. DATE OF RETURN		38. DATE OF REENTRY		39. DATE OF EXIT		40. DATE OF REENTRY	
41. DATE OF DEPARTURE		42. DATE OF RETURN		43. DATE OF REENTRY		44. DATE OF EXIT		45. DATE OF REENTRY	
46. DATE OF DEPARTURE		47. DATE OF RETURN		48. DATE OF REENTRY		49. DATE OF EXIT		50. DATE OF REENTRY	
51. DATE OF DEPARTURE		52. DATE OF RETURN		53. DATE OF REENTRY		54. DATE OF EXIT		55. DATE OF REENTRY	
56. DATE OF DEPARTURE		57. DATE OF RETURN		58. DATE OF REENTRY		59. DATE OF EXIT		60. DATE OF REENTRY	
61. DATE OF DEPARTURE		62. DATE OF RETURN		63. DATE OF REENTRY		64. DATE OF EXIT		65. DATE OF REENTRY	
66. DATE OF DEPARTURE		67. DATE OF RETURN		68. DATE OF REENTRY		69. DATE OF EXIT		70. DATE OF REENTRY	
71. DATE OF DEPARTURE		72. DATE OF RETURN		73. DATE OF REENTRY		74. DATE OF EXIT		75. DATE OF REENTRY	
76. DATE OF DEPARTURE		77. DATE OF RETURN		78. DATE OF REENTRY		79. DATE OF EXIT		80. DATE OF REENTRY	
81. DATE OF DEPARTURE		82. DATE OF RETURN		83. DATE OF REENTRY		84. DATE OF EXIT		85. DATE OF REENTRY	
86. DATE OF DEPARTURE		87. DATE OF RETURN		88. DATE OF REENTRY		89. DATE OF EXIT		90. DATE OF REENTRY	
91. DATE OF DEPARTURE		92. DATE OF RETURN		93. DATE OF REENTRY		94. DATE OF EXIT		95. DATE OF REENTRY	
96. DATE OF DEPARTURE		97. DATE OF RETURN		98. DATE OF REENTRY		99. DATE OF EXIT		100. DATE OF REENTRY	

03243

03544

CERTIFICATE OF DEATH

03537

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE (RURAL)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY	
c. LENGTH OF STAY IN lb 15 DAYS		d. STREET ADDRESS 683 FITZWATER STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Brewster DUFFY Middle DUFFY Last BREWSTER		4. DATE OF DEATH MARCH 22 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1882 ? 4-15-82 9. AGE (In years last birthday) 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN SAUNDERS DUFFY		14. MOTHER'S MAIDEN NAME UNKNOWN ANNIE WILLIAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 213-12-5219	
17. INFORMANT RECORDS OF THE EASTERN SHORE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Arteriosclerosis (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH one day 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/7 , 1967, to 3/22 , 1967, that (I) (we) last saw the deceased alive on 3/22 , 1967, and that death occurred at 7:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Fernandez		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) EFRAIN C. FERNANDEZ		22d. ADDRESS E.S.S.S. Cambridge, Dorchester, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-28-67	
23c. NAME OF CEMETERY OR CREMATORY Friendship		23d. LOCATION (City or Town) (County) (State) Whiton - Worcester, Maryland	
24. FUNERAL DIRECTOR Loretta L. Jolley - Jerry Rd. Salisbury Md		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE MAR 31 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

SEED

4350

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03545					CERTIFICATE OF DEATH			03538		
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 2, Easton 20-2					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Samuel Ervin Glasco					4. DATE OF DEATH March 14 1967					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH II-II-1896		9. AGE (In years lost birthday) yrs. 70 IF UNDER 1 YEAR: Months 4 Days 3 Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY sawmill		11. BIRTHPLACE (County & State, or foreign country) Federalsburg, Va.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Glasco					14. MOTHER'S MAIDEN NAME UN KNOWN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 220-32-8887		17. INFORMANT Franklin Lee Tilghman			Address Rt. 2, box IIO Easton, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia; Cardiac Decompensation 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Renal Disease DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from December 1, 1966 , to March 14, 1967 , that (I) (we) last saw the deceased alive on March 11, 1967 , and that death occurred at _____ M, from causes and on the date stated above.										
22a. SIGNATURE <i>J. Edwin Fassett</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 3-14-67		
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.					22d. ADDRESS 623 High St., Cambridge, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 18, 1967		23c. NAME OF CEMETERY OR CREMATORY Richard's Mem. Park			23d. LOCATION (City or Town) (County) (State) Easton Talbot Md.			
24. FUNERAL DIRECTOR G.H. Dashiell					ADDRESS Easton, Md.		25a. REC'D BY REGISTRAR DATE MAR 21 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

28750

2328

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03546

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03539

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dor.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Vienna</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Vienna</u> 09-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		d. STREET ADDRESS <u>Middle St.</u>	
3. NAME OF DECEASED (Type or print) <u>Linnie Rebecca Gray</u>		4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/1/1908</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Harry Bell</u>		14. MOTHER'S MAIDEN NAME <u>Georgia Bennett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Shelton E. Gray</u>		Address <u>Vienna, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>None</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3/9/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dor. Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Cambridge Md</u>
24. FUNERAL DIRECTOR <u>Ruth S. Millonghly, East New Market, Md</u>		25. MAR 13 1967	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03223

03223

03547

CERTIFICATE OF DEATH

03540

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN lb <u>27 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>Landing Neck, Trappe</u>	
3. NAME OF DECEASED (Type or print) <u>John H. Harrison</u>		4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-03-1881</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm-r</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harrison William H.</u>		14. MOTHER'S MAIDEN NAME <u>Morgan, Matilda</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-54-9975</u>	
17. INFORMANT <u>Spedden, Harrison</u>		Address <u>401 Leonards Cambridge, Md. Len.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Joint degenerative disease (advanced)</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>7230</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 3</u> , 19 <u>67</u> , to <u>March 30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 30</u> , 19 <u>67</u> , and that death occurred at <u>1:35</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Carlos F Barrios</u>		22b. DATE SIGNED <u>3-30-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CARLOS F. BARRIOS</u>		22d. ADDRESS <u>Eastern Shore State Hosp. Dorchester Cambridge Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>4-1-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL</u>	23d. LOCATION (City or Town) (County) (State) <u>EASTON TALBOT MD</u>
24. FUNERAL DIRECTOR <u>Alan Bank</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05250

5438

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03548

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03541

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		c. LENGTH OF STAY IN Tb 10 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Beulah		d. STREET ADDRESS R.F.D. #2, Box 46	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle JOHN Last HUBBARD SR.		4. DATE OF DEATH Month March Day 30 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 16, 1916
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press Operator		10b. KIND OF BUSINESS OR INDUSTRY Maryland Plastics	9. AGE (In years lost birthday) yrs. 50
11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ralph Fisher Hubbard		14. MOTHER'S MAIDEN NAME Mary Ida Hubbard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-9192	
17. INFORMANT Mrs. Audrey Lee Hubbard, Hurlock, Md., RFD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) John Mace Jr. M.D.		22. DATE SIGNED 4/4/67 Address (Street, city, town, or county) Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	April 2, 1967	Junior Order Cemetery	Preston, Maryland
24. FUNERAL DIRECTOR <i>J. J. Frampton</i> J. J. Frampton and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR APR 7 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Young</i>

03241

03248

10/10/10

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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2

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
03549					MEDICAL EXAMINER'S CERTIFICATE OF DEATH					03542				
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN 1b years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge 09-1									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Cambridge Maryland Hospital					d. STREET ADDRESS 1010 Washington Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First LLOYD Middle E. Last JAMES					4. DATE OF DEATH Month March Day 2 Year 1967									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 26, 1890		9. AGE (In years last birthday) yrs. 76						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Horseman			10b. KIND OF BUSINESS OR INDUSTRY Racing			11. BIRTHPLACE (State or foreign country) Hurlock, Maryland			12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME William James					14. MOTHER'S MAIDEN NAME Hattie /?									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. unk		17. INFORMANT Mrs. Lloyd E. James, Cambridge, Maryland Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary occlusion DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH Instant					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE John Mace Jr. M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> 3/3/67									
EXAMINER'S NAME (Type) John Mace Jr. M.D.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Cambridge, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Mar 5, 1967		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memoria 1 Park		23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland							
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland ADDRESS					25a. REC'D BY REGISTRAR DATE MAR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge							

02750

02750

02750

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03550

CERTIFICATE OF DEATH

03543

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 10 wks.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital, Inc.		d. STREET ADDRESS R.F.D. #2 Cambridge, Md.	
3. NAME OF DECEASED (Type or print) First Middle Last Charles W. Jolley		4. DATE OF DEATH Month Day Year March 13 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1901
9. AGE (In years last birthday) yrs. 66		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Jolley, Sr.		14. MOTHER'S MAIDEN NAME Charolett Camper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-38-0476	
17. INFORMANT Nettie Jolley		Address R.F.D. #2 Cambridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Renal Disease DUE TO (c) -----			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 14, 19 67 , to March 13, 19 67 , that (I) (we) last saw the deceased alive on March 13, 19 67 , and that death occurred at ----- M, from causes on and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 3-13-67	
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		22d. ADDRESS 623 High Street Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/18/67	23c. NAME OF CEMETERY OR CREMATORY Bethel	23d. LOCATION (City or Town) (County) (State) Cambridge Dorchester Md.
24. FUNERAL DIRECTOR <i>[Signature]</i>		ADDRESS Cambridge, Md.	25a. REC'D BY REGISTRAR DATE MAR 15 1967
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

08288

CERTIFICATE OF DEATH

08288

MAR 19 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03551

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03544

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Maryland Hospital		d. STREET ADDRESS RFD	
3. NAME OF DECEASED (Type or print) First James Middle Arch Last Jolley		4. DATE OF DEATH Month March Day 7 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 11, 1872
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 7 Days 19 Hours 1 Min. 09-1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-52-8849	
17. INFORMANT Mrs. Rachel E. Johnson, Hurlock, Md., RFD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Neoplasm, right Apex of lung		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Possible reinfection Pulmonary Tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 18, 1967 , to March 7, 1967 , that (I) (we) last saw the deceased alive on March 7, 1967 , and that death occurred at 7 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE J. Edwin Fassett, M.D.		22b. DATE SIGNED 3-7-67	
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		22d. ADDRESS 623 High St., Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 9, 1967	
23c. NAME OF CEMETERY OR CREMATORY Petersburg Cemetery		23d. LOCATION (City, town or county) (State) Near Hurlock, Maryland	
24. FUNERAL DIRECTOR J. J. Framptom and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR MAR 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

03254

03254



VR A15 (4)
20M 1/65

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BRENDA		4. DATE OF DEATH Month March Day 21 Year 19 67	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29, 1945	
9. AGE (In years last birthday) 21 yrs.		10. IF UNDER 1 YEAR Months 21 Days 21 Hours 21 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY Home	
13. FATHER'S NAME George Horner		14. MOTHER'S MAIDEN NAME Olive Larimore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Mr. Warren E. Larson, Cambridge, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 445X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Chronic Glomerular nephritis DUE TO (c) Malignant hypertension and anemia		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1958 , 19____, to 3-21-67 , 19____, that (I) (we) last saw the deceased alive on 3-20-67 , 19____, and that death occurred at 12:40 PM from the causes and on the date stated above.			
22a. SIGNATURE Albert E. Bunker		22b. DATE SIGNED 3-22-67	
22c. PHYSICIAN'S NAME (Type) ALBERT E. BUNKER M. D.		22d. ADDRESS 200 Md. Ave., Cambridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 23, 1967	
23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City, town or county) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR MAR 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

03332

03332

DEPARTMENT OF DEFENSE

MEMORANDUM FOR THE SECRETARY OF DEFENSE

SUBJECT: [Illegible]

DATE: [Illegible]

FROM: [Illegible]

TO: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

FOR STATE
HEALTH DEPT.

03553

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03546

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>	
c. LENGTH OF STAY IN 1b <u>4 mon. 4 days</u>		d. STREET ADDRESS <u>ELm Street, Route #1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Robert</u> Last <u>Massey</u>		4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/28/1888</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>15</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coast Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Wm. Massey</u>		14. MOTHER'S MAIDEN NAME <u>Owllen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>Coast Guard</u> <u>217-44-2042</u>		16. SOCIAL SECURITY NO. <u>217-44-2042</u>	
17. INFORMANT <u>East RN Shore State Hosp. (Medical Record)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>CEREBRAL VASCULAR ACCIDENT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> DUE TO <u>—</u>		INTERVAL BETWEEN DEATH AND DEATH <u>25 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.		22. DATE SIGNED <u>3/15/67</u>	
EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	23d. LOCATION (City or Town) (County) (State) <u>Berlin Worcester Md.</u>
24. FUNERAL DIRECTOR <u>Anne A. Burbay</u> ADDRESS <u>Berlin Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 17 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1252

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME
SM 1/63

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			c. LENGTH OF STAY IN 1b <u>entire life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			d. STREET ADDRESS <u>604 Glasgow Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>604 Glasgow Street</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gilbert Edison Meekins</u>					4. DATE OF DEATH Month Day Year <u>Mar. 22, 1967</u> 19				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 14, 1892</u>		9. AGE (In years last birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cambridge</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>William W. Meekins</u>					14. MOTHER'S MAIDEN NAME <u>Manie E. Hackett</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>					16. SOCIAL SECURITY NO. <u>W.W. I</u>				
17. INFORMANT <u>Mrs. Virginia J. Meekins, Cambridge, Md.</u>					Address: <u>604 Glasgow St.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Cambridge, Md.</u> DATE SIGNED <u>3/23/67</u> ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D. EXAMINER'S NAME (Type) <u>John Mace Jr. M.D.</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Mar. 25, 1967</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Christ Churchyard</u> 22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u> 23. FUNERAL DIRECTOR <u>Kenneth A. Thomas, Jr.</u> ADDRESS <u>Cambridge, Md.</u> 24a. REC'D BY REGISTRAR <u>MAR 27 1967</u> 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

03554

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03555					03548				
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bell Haven Nursing Home					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 211 Shad Point Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First LULA Middle ELLEN Last MILLS			4. DATE OF DEATH Month March Day 2 Year 1967						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 29, 1884		9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR Months 6 Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Md.			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry W. Mills					14. MOTHER'S MAIDEN NAME Mary E. Hopkins				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Pansey E. Bedsworth (Niece) 211 Shad Point Rd., Salisbury, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 260X DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 6 hours 10 years 25 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from December 11, 1966 , to March 2, 1967 , that (I) (we) last saw the deceased alive on March 2, 1967 , and that death occurred at 4 P M , from the causes and on the date stated above.									
22a. SIGNATURE Carlos F Barroso					22b. DATE SIGNED March 3 /1967				
22c. PHYSICIAN'S NAME (Type) CARLOS F BARROSO					22d. ADDRESS Hurlock, Dorchester Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF March 5, 1967		23c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery		23d. LOCATION (City, town or county) (State) Salisbury, Maryland		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND					25a. REC'D BY REGISTRAR MAR 6 1967		25b. REGISTRAR'S SIGNATURE [Signature]		

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EXHIBIT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
03556					CERTIFICATE OF DEATH					03549				
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge					c. LENGTH OF STAY IN 1b 3 mths					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Church Creek				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge, Maryland Hospital					d. STREET ADDRESS None					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First SARAH Middle KATHERINE Last MILLS					4. DATE OF DEATH Month March Day 18 Year 19 67									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 30, 1873		9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Madison, Maryland			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Columbus Hall					14. MOTHER'S MAIDEN NAME Susan Trego									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 214-54-9703		17. INFORMANT Mr. Carl R. Mills, Church Creek, Maryland					Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 545X PYLORIC OBSTRUCTION (UNDIETETERMINED) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 5 DAYS				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 13 MAR 1967 to 18 MAR 1967 , that (I) (we) last saw the deceased alive on 17 MAR 1967 , and that death occurred at 10A M , from the causes and on the date stated above.														
22a. SIGNATURE W.E. GUNBY JR.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <input type="checkbox"/>					22b. DATE SIGNED 3/20/67				
22c. PHYSICIAN'S NAME (Type) W.E. GUNBY JR.					22d. ADDRESS CAMBRIDGE MD									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Mar 21 1967		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery			23d. LOCATION (City, town or county) (State) Cambridge, Maryland						
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland					ADDRESS					25a. REC'D BY REGISTRAR MAR 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03557

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03550

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b DQA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DQA Cambridge Maryland Hospital		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First BRADY Middle W. Last MORRIS		4. DATE OF DEATH Month March Day 3 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1905
9. AGE (In years and birthday) 62 yrs.		IF UNDER 1 YEAR Months 09 Days -1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leander Morris		14. MOTHER'S MAIDEN NAME Anna Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Mrs. Hazel M. Morris		Address Bishops Head, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 3/3/67	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 5, 1967	
23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR DATE MAR 6 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03558

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03551

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	c. LENGTH OF STAY in lb 10 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Golden Hill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		d. STREET ADDRESS None	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle C. Last MURPHY		4. DATE OF DEATH Month March Day 25 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher-retired		10b. KIND OF BUSINESS OR INDUSTRY School	9. AGE (In years lost birthday) yrs. 72
11. BIRTHPLACE (State or foreign country) East Freedom, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael C. Murphy		14. MOTHER'S MAIDEN NAME Ellen C. Murphy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. unk	17. INFORMANT Miss Anne B. Murphy, Golden Hill, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Fracture left femur DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 hr. 9 days.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down steps in home		
20c. TIME OF INJURY Month, Day, Year 8:30 PM 3/15/67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work Home	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Golden Hill Dor. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		22. DATE SIGNED 3/27/67	
EXAMINER'S NAME (Type) John Mace Jr.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar 29, 1967	23c. NAME OF CEMETERY OR CREMATORY Star Of The Sea Cemetery	23d. LOCATION (City or Town) (County) (State) Golden Hill, Maryland
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR MAR 31 1967	25b. REGISTRAR'S SIGNATURE J Charles Judge

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03556

[Faint, mostly illegible text covering the majority of the page, appearing to be a document or report.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <div>035559</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div> <div>CERTIFICATE OF DEATH</div> <div>03552</div> </div> </div>															
1. PLACE OF DEATH a. CDUNITY <u>Dorchester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u> c. LENGTH OF STAY IN 1b <u>30 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Belle Haven Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u> d. STREET ADDRESS <u>Liberty Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>HERBERT</u> Last <u>O'DAY</u>			4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>19 67</u>		5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 14, 1878</u>		9. AGE (In years last birthday) <u>88</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House Painter</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Caroline County, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Charles O'Day</u>						14. MOTHER'S MAIDEN NAME <u>Rhoda Knox</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>158-14-9844</u>		17. INFORMANT <u>Mollie B. O'Day, Federalsburg, Maryland</u> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5020 Congestive heart failure</u> (b) <u>Chronic bronchitis and emphysema</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>10 days.</u> <u>10 years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>March 3, 1967</u> , to <u>March 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 22, 1967</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.															
22a. SIGNATURE <u>Carlos F. Barroso</u>												22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Carlos F. Barroso</u>						22d. ADDRESS <u>Hurlock, Maryland</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>March 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Federalsburg, Maryland</u>					
24. FUNERAL DIRECTOR <u>J. S. Frampton and Son</u> ADDRESS <u>Federalsburg, Maryland</u>						25a. REC'D BY REGISTRAR <u>MAR 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

MEDICAL CERTIFICATION

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MAR 2 1967

CERTIFICATE OF DEATH

03560

03553

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>4 mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nancy Olivia Phillips</u>		4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-80</u>
9. AGE (In years lost birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>19</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Columbus Short</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Lord</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Eastern Shore State Hosp.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS, GENERALIZED</u> DUE TO (b) <u>CARCINOMA OF CERVIX</u> DUE TO (c) <u>ARTERIOSCLEROSIS, CHRONIC BRAIN SYNDROME</u>		INTERVAL BETWEEN ONSET AND DEATH <u>ABOUT 1YR</u> <u>ABOUT 1YR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>he</u> (this hospital) attended the deceased from <u>Nov. 19, 1966</u> , to <u>MAR. 19, 1967</u> , that (I) <u>was</u> last saw the deceased alive on <u>MAR. 19, 1967</u> , and that death occurred at <u>2:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edward Lewis Jr. M.D.</u>		22b. DATE SIGNED <u>3-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD LEWIS, JR., M.D.</u>		22d. ADDRESS <u>Eastern Shore State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/22/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		23d. LOCATION (City or Town) (County) (State) <u>East New Market, Md.</u>	
24. FUNERAL DIRECTOR <u>Duth & Thibault</u>		25a. REC'D BY REGISTRAR <u>MAR 21 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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VR A15 (4)
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
03561					CERTIFICATE OF DEATH					03554									
1. PLACE OF DEATH a. COUNTY Dorchester					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester														
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge					c. LENGTH OF STAY IN ID Life					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 101 Glenburn Avenue					d. STREET ADDRESS 101 Glenburn Avenue					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First REGINALD Middle JAMES Last PHILLIPS					4. DATE OF DEATH Month March Day 22 Year 19 67														
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 2, 1898		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter-Retired				10b. KIND OF BUSINESS OR INDUSTRY General Building				11. BIRTHPLACE (County & State, or foreign country) Cambridge, Maryland				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Levin H. Phillips					14. MOTHER'S MAIDEN NAME Emma Brannock														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. unk					17. INFORMANT Address Mrs. Reginald J. Phillips, Cambridge, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Adenocarcinoma Lung DUE TO (c) 2 was										INTERVAL BETWEEN ONSET AND DEATH 6 mos									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
					20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from July , 19 67 , to March 22 , 19 67 , that (I) (we) last saw the deceased alive on March 22 , 19 67 , and that death occurred at 9:15 M., from the causes and on the date stated above.																			
22a. SIGNATURE W. N. Baumann										22b. DATE SIGNED 3-23-67									
22c. PHYSICIAN'S NAME (Type) Wilbur N. Baumann, MD										22d. ADDRESS 10 Aurora St., Cambridge, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Mar 25 1967					23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park									
					23d. LOCATION (City, town or county) (State) Cambridge, Maryland														
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland										25a. REC'D BY REGISTRAR MAR 27 1967					25b. REGISTRAR'S SIGNATURE Charles Judge				

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EXHIBIT 2 OF 2

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #2d Film #G386 3/4/67 pc														
03562					MEDICAL EXAMINER'S CERTIFICATE OF DEATH					03555				
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN 1b 15 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge					09-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1005 Race Street					d. STREET ADDRESS 1005 1105 Race Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First HATTIE Middle SLACUM Last PRITCHETT					4. DATE OF DEATH Month March Day 2 Year 19 67									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1877		9. AGE (In years lost birthday) yrs. 89		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland			12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Lemuel Slacum					14. MOTHER'S MAIDEN NAME Alice Pritchett									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. George Powley, Wingate, Maryland			Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO										INTERVAL BETWEEN ONSET AND DEATH Instant				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE John Mace Jr. M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22. DATE SIGNED 3/3/67				
EXAMINER'S NAME (Type) John Mace Jr. M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Cambridge, Md.				
Address (Street, city, town, or county)														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Mar 4, 1967		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park			23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland						
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland					ADDRESS		25a. REC'D BY REGISTRAR MAR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03563

CERTIFICATE OF DEATH

03556

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>3 mos</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Md</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp.</u>			d. STREET ADDRESS <u>1002 Bell Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JULIA CHARL RAWSON</u>			4. DATE OF DEATH Month Day Year <u>3 12 1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>01-01-89</u>		9. AGE (In years lost birthday) <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Retired) Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-30-0448</u>		17. INFORMANT Address <u>Salisbury, Md.</u> <u>Mr. Joseph B. Rawson</u> & <u>Mr. William H. Rawson (Step-Son)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA + empyema, P.</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>OBESITY, DIABETES MELLITUS, ARTERIOSCLEROSIS</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>12-14</u> , 19 <u>66</u> , to <u>3-12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-12-67</u> at <u>8:45 PM</u> , and that death occurred at <u>8:45 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Felipe M. Dominguez</u> M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-12-67</u>
22c. PHYSICIAN'S NAME (Type) <u>FELIPE M. DOMINGUEZ</u>			22d. ADDRESS <u>E.S.D. Cambridge, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 15, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>			25a. REC'D BY REGISTRAR DATE <u>MAR 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Richard Dudge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03564		03557	
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 2 hrs. 32 Min. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital Inc.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 744 Cornish Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sampson Middle Sampson Last Sampson		4. DATE OF DEATH Month March Day 24 Year 19 67	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (in years last birthday) 2 yrs. IF UNDER 1 YEAR Months 2 Days 32 IF UNDER 24 HRS. 32
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Dorchester	
13. FATHER'S NAME Joe Louis Sampson		14. MOTHER'S MAIDEN NAME Doretha Leona Travers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. Doretha Sampson-744 Cornish Dr. Camb. Md.	
17. INFORMANT Doretha Sampson-744 Cornish Dr. Camb. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity---Immaturity 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-24 , 19 67 , to 3-24 , 19 67 , that (I) (we) last saw the deceased alive on 3-24 , 19 67 , and that death occurred at 5:50 PM from the causes and on the date stated above.			
22a. SIGNATURE Eldridge H. Wolff		22b. DATE SIGNED 3-24-67	
22c. PHYSICIAN'S NAME (Type) Dr Eldridge H. Wolff		22d. ADDRESS 6 Aurora St Cambridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Disposed of		23b. DATE THEREOF 3-25-67	
23c. NAME OF CEMETERY OR CREMATORY Cambridge Maryland Hospital		23d. LOCATION (City, town or county) (State) Cambridge Maryland	
24. FUNERAL DIRECTOR Irma Skinner Cambridge Md		25a. REC'D BY REGISTRAR Charles Yuja	
25b. REGISTRAR'S SIGNATURE Charles Yuja		25c. DATE MAR 29 1967	

03252

03252

03252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03565					03558						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Dorchester					a. STATE Maryland b. COUNTY Dorchester						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) East New Market						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryla nd Hospital					d. STREET ADDRESS						
3. NAME OF DECEASED (Type or print) First ROBIN Middle LYNN Last SCHUYLER					4. DATE OF DEATH Month March Day 4 Year 19 67						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 10, 1965		9. AGE (In years last birthday) 1 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Easton, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		9-1			
13. FATHER'S NAME Nathan L. Schuyler					14. MOTHER'S MAIDEN NAME Juanita Mae Greenhawk						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Nathan L. Schuyler, East New Market, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anemia - iron deficiency - Scleroderma										INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 3-3 , 19 67 , to 3-4 , 19 67 , that (I) (we) last saw the deceased alive on 3-4 , 19 67 , and that death occurred at 5:15 M, from the causes and on the date stated above.											
22a. SIGNATURE [Signature]								22b. DATE SIGNED 3-6-67			
22c. PHYSICIAN'S NAME (Type) [Signature]					22d. ADDRESS [Signature]						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Mar 6, 1967		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City, town or county) (State) Cambridge, Maryland				
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland					25a. REC'D BY REGISTRAR MAR 9 1967		25b. REGISTRAR'S SIGNATURE [Signature]				

03255

03255

On the 1st of January 1967, the following persons were present at the meeting of the Board of Directors of the Corporation:

Name	Address	Signature
John A. Smith	123 Main Street, New York, N.Y.	[Signature]
Jane D. Doe	456 Elm Street, New York, N.Y.	[Signature]
Robert E. Brown	789 Oak Street, New York, N.Y.	[Signature]
William F. Green	101 Pine Street, New York, N.Y.	[Signature]
Charles H. White	202 Cedar Street, New York, N.Y.	[Signature]
Thomas J. Black	303 Birch Street, New York, N.Y.	[Signature]
Elizabeth K. Gray	404 Spruce Street, New York, N.Y.	[Signature]
James L. Blue	505 Willow Street, New York, N.Y.	[Signature]
Margaret M. Red	606 Hickory Street, New York, N.Y.	[Signature]
Richard N. Yellow	707 Chestnut Street, New York, N.Y.	[Signature]
Susan P. Purple	808 Walnut Street, New York, N.Y.	[Signature]
David Q. Green	909 Maple Street, New York, N.Y.	[Signature]
Linda R. Brown	1010 Elm Street, New York, N.Y.	[Signature]

Respectfully,
[Signature]
President

1011 Elm Street, New York, N.Y.
1012 Elm Street, New York, N.Y.
1013 Elm Street, New York, N.Y.
1014 Elm Street, New York, N.Y.
1015 Elm Street, New York, N.Y.

Witnessed and attested to the presence of the Board of Directors on the 1st day of January, 1967.

Notary Public
[Signature]
MAR 8 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03566				CERTIFICATE OF DEATH				03559	
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hudson				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital					d. STREET ADDRESS None			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDDIE Middle A. Last SEWARD					4. DATE OF DEATH Month March Day 18 Year 1967				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 28, 1885		9. AGE (In years last birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Hudson, Maryland			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Seward					14. MOTHER'S MAIDEN NAME Carrie Palmer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 217-54-7346		17. INFORMANT Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PERIPHERAL CIRCULATORY FAILURE 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HT. DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY DECOMPENSATION								INTERVAL BETWEEN ONSET AND DEATH 12 HRS UNDER	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 3/16 , 19 67 , to 3/18 , 19 67 , that (I) (we) last saw the deceased alive on 3/18 19 67 , and that death occurred at 6 PM , from the causes and on the date stated above.									
22a. SIGNATURE Alfred R. Maryanov								22b. DATE SIGNED 3/20/67	
22c. PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV								22d. ADDRESS 610 RACE ST, CAMBRIDGE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 21 1967		23c. NAME OF CEMETERY OR CREMATORY Spedden-Seward Cemetery			23d. LOCATION (City, town or county) (State) James, Maryland		
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland					25a. REC'D BY REGISTRAR MAR 23 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge		

03550

03550

1952

MAR 2 1952

03567

CERTIFICATE OF DEATH

03560

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND x		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Taibot</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels Maryland</u>	
c. LENGTH OF STAY IN 1b <u>16 mos 26 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>20-2</u>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>A</u> Middle <u>Thomas</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>02-17-71</u>
9. AGE (In years lost birthday) <u>96</u> yrs.		IF UNDER 1 YEAR Months <u>26</u> Days <u>26</u> Hours <u>26</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during mos't of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFARER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Sturwood, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>218-20-9228</u>	
17. INFORMANT <u>Eastern Shore State Hosp. (Medical Record)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>? myocardial infarction</u> DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>N.A.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>10-19-</u> , 19 <u>65</u> , to <u>3-15-</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>3-15-</u> 19 <u>67</u> , and that death occurred at <u>6:10</u> A.M. from causes on and on the date stated above.			
22a. SIGNATURE <u>John Blair Webster</u>		22b. DATE SIGNED <u>3-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN BLAIR WEBSTER</u>		22d. ADDRESS <u>CAMBRIDGE, MTD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar 17, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>St. Michaels Maryland</u>	
24. FUNERAL DIRECTOR <u>Harmon Leonard</u>		25. REC'D BY REGISTRAR <u>St. Michael</u>	
25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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09250

7230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03568				Items 13 & 14 Film 0387-1/12767-nb				03561			
1. PLACE OF DEATH a. COUNTY Dorchester				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE md.				b. COUNTY Dorchester			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b life				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS 210 Belvedere Ave/				e. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) S. Earl Webster				4. DATE OF DEATH 3/6/67				Month Day Year 19			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/15/1904		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) druggist				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Crapo, Dorchester, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willie Worton/ Samuel Dewberry Webster				14. MOTHER'S MAIDEN NAME Dewberry Willie I. Wroten							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. unk.				17. INFORMANT Address Mrs. Evelyn Robinson Webster, Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Myocardial Infarction 4201 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) Arterio-sclerosis generalized										INTERVAL BETWEEN ONSET AND DEATH 12 Min. 6 Mo. 1 Yr. +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Lymphatic Leukemia, asymptomatic										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (as hospital) attended the deceased from 1-4- , 19 67 , to 3-6- , 19 67 , that (I) (we) last saw the deceased alive on 3-6- , 19 67 , and that death occurred at 9:20 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Eldridge H. Wolff				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 3-7-67			
22c. PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M. D.				22d. ADDRESS 6 Aurora Street, Cambridge, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/8/67		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park Cambridge, Md. Dorchester				23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR LeCompte Funeral Service Cambridge, Md.				25a. REC'D BY REGISTRAR MAR 13 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			

03561

03568

3/1/1

1. 1911

1911/1912

1911/1912

1911/1912

1911/1912

1911/1912

Massive myocardial infarction

Coronary atherosclerosis

Arterio-sclerotic generalization

Chronic lymphatic leukemia, asymptomatic

1911/1912

1911/1912

1911/1912

1911/1912

1911/1912

1911/1912

1911/1912

1911/1912

1911/1912

1911/1912